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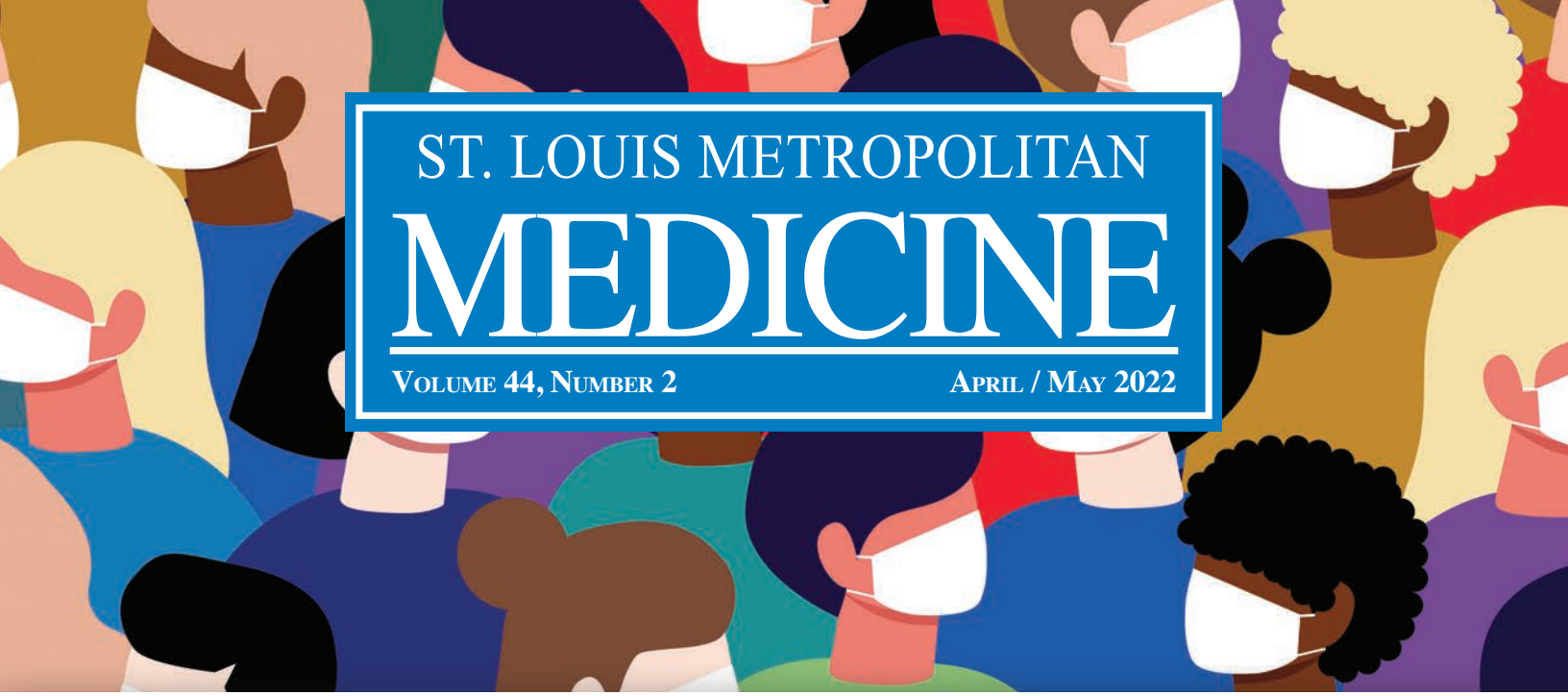

COVID-19 and Health Equity

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The Impending Physician Workforce Crisis

COVID-19 stressors compound ongoing burnout issues

By Erin S. Gardner, MD, President, St. Louis Metropolitan Medical Society 2022

Erin S. Gardner, MD

A study from the American Medical Association indicates that nearly one in four physicians surveyed plans on leaving the workforce within two years.[1]

The once-in-a-hundred-years pandemic appears to be in its waning hours. Most observers believe we are moving to a novel coronavirus-endemic world. A phenomenon as profound as the COVID-19 pandemic has provoked lasting changes in the way we live, and one of the most worrying consequences of the pandemic affects our own realm, i.e., health care delivery. Recent studies indicate that our health care workforce is in danger of mass retirements or departures as we move to the post-pandemic world. This is a trend that we in health care and society generally must address with dispatch and discernment.

A study from the American Medical Association indicates that nearly one in four physicians surveyed plans on leaving the workforce within two years.[1] That is an astounding number, especially in light of the physician workforce strain and shortage that already exists in our nation. The American Association of Medical Colleges' most recent forecast for the physician workforce showed shortages somewhere between approximately 38,000 and 124,000 physicians by 2034.[2] And a more contemporary snapshot using public polling found that 35% of survey respondents indicated that they or someone they knew had trouble finding a physician in the past year or two (which was up 10 points from 2015).[3]

The AMA study showed that COVID-19 factors played a significant role in influencing a respondent's intent to leave the workforce. The high stress of health care delivery during the pandemic, fear of self or family exposure, the heavy workload and associated feelings of anxiety or depression were among the several factors that contributed. The COVID-19 stressors compounded the original burnout culprits that had simmered for years prior to the pandemic: declining physician autonomy, treating the data not the patient, a health care milieu beset by arcane and complex rules, a rewards system where negative consequences have outsized effects over positive consequences, a sense of powerlessness within the system, and electronic health record woes.[4]

The AMA study's survey period concluded at the beginning of 2021, in the deep of the pandemic, so there remains hope that more optimistic, lower-stress times will alter the course of the projection. Yet previous studies on physician workforce exit showed that intent to leave as expressed in surveys correlated subsequently with actual workforce departures.[1]

Opportunities to Stem the Crisis

There remain opportunities to blunt this ominous foreboding. Very late in 2020, bipartisan legislation was passed to steadily increase graduate medical education residency slots by 200 per year for five years. Regrettably, this came after a 25-year freeze on the number of government-supported GME residency slots. Yet it remains a step in the right direction, and subsequent bipartisan legislation in 2021 proposed to increase the number of residency slots by 2,000 per year in fiscal years 2023 to 2029 (Resident Physician Shortage Act of 2021).

Hospitals and organizations that address the sequelae from pandemic-type care can help to ameliorate some of the key factors influencing contemplated career decisions. The AMA study showed that physicians who felt highly valued by their organization, or felt a strong sense of meaning and purpose in their work, were less likely to state a desire to leave their practices. Certainly there was a steep learning curve for hospitals and organizations when initially confronted by the pandemic; yet, now we have the time and greater insight to plan and deploy measures that address physician needs and concerns, and generally to appreciate the efforts of those on the front line.

Determinedly continuing this work on other core contributors to disaffection and burnout remains fertile ground for improvements, too. The toil and labors associated with electronic documenting by the physician have been addressed to varying extents by vendors and organizations; and CMS' slimmed documenting requirements inaugurated in 2021 have further contributed to reduced frustration and consternation. Efforts in state legislatures to curb convoluted insurance company requirements for tasks like prior authorization have helped. Greater attentiveness to physician well-being by organizations, led and guided by physician input and feedback, has contributed to diminished day-to-day stress and has opened avenues to self-care that is salubrious.

We must work to encourage those newly considering medicine as a career. They are our future.

Many of us physicians believe that the best health care is delivered by a team of health care personnel, with physicians at the head of those teams. That is a core principle that guides our advocacy for the practice of medicine and scope of practice considerations. Yet, if there are too few physicians, the principle is compromised, and society will seek alternative solutions to address health care needs. I urge you to consider how you can today take action and speak on this ongoing and pressing problem.

What You Can Do

Will you write a letter to your U.S. representative and senator, describing how you see daily the troubles that derive from too few physicians in our ranks? Or will you write a letter to your state representative or senator, detailing how patient care is optimized and aimed toward excellence by organizing health care teams, led by physicians, which coordinate to deliver that which a patient needs? *(For tips on contacting members of Congress and constructing a letter or email, see pages 4-7 of the AMA pamphlet "Congressional Checkup: A Guide to Physician Advocacy." https://bit.ly/advoc-guide)*

And finally, we must work to encourage those newly considering medicine as a career. They are our future. We can beckon those who otherwise might be stirred by the siren song of sometimes glamorous alternative occupations. We can recruit within underrepresented populations that might not otherwise consider medicine as a profession. Our aim should be to encourage the best and the brightest to seek and embrace a career in medicine. All of us physicians have been shown excellence in attaining the practice of a physician, and we should aspire to show it to our successors as well … our patients deserve nothing less.

Erin S. Gardner, MD, is a board-certified dermatologist and Mohs surgeon in private practice with Dermatology Specialists of St. Louis.

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Attracting and Retaining Patients in the Digital Age

Online portals, patient reviews gain increasing importance

By David M. Nowak, Medical Society Executive Vice President

David M. Nowak

As digital consumerism in health care grows, expectations for the patient experience continue to evolve in equal measure.

As a "late-stage baby boomer" (generally defined as those born between 1957 and 1964), I often find myself dragging my feet into the 21st century and longing for the old ways of doing things. More than anything, I feel frustrated by the increasing lack of human contact and less use of interpersonal communication skills in many routine day-to-day interactions.

But as we continue to emerge from the pandemic of the past two years, historians will surely note that one of the greatest outcomes of COVID-19 will be the accelerated adoption of digital tools. As we stayed more in our homes and smaller social circles, we turned to performing more tasks online, and even "somewhat old" people like me were forced to embrace new technology. And much to our surprise, we are finding that we actually like it.

Today's consumer expects a seamless digital experience in everything from ordering a meal to paying a bill to purchasing theater tickets. And the traditionally high human-interaction world of health care is no different. Never was that more apparent to me than when I recently read Press Ganey's *Consumer Experience Trends in Healthcare 2021 Report*.

Many of us are familiar with Press Ganey's work collecting and tabulating patient satisfaction data from more than 40,000 health care clients. During September 2021, the company surveyed more than 1,100 U.S. consumers, across demographics of region, gender, income and age. Their survey findings advise health care leaders to prioritize their digital consumerism strategies not only to keep up with current expectations, but to also successfully acquire and retain patients for years to come.[1]

As digital consumerism in health care grows, expectations for the patient experience continue to evolve in equal measure. The research concludes that the "patient experience" can no longer be defined by the clinical care setting alone. Today, it encompasses every step of the health care journey, from researching doctors to scheduling—and even conducting appointments.[1]

Some topline findings of the study:

- **Digital drives choice**—patients rely on digital resources 2.2 times more than provider referrals when choosing a health care provider.
- **The rise of virtual health**—over one-third of patients have used telehealth in the past year, a 337% increase since 2019.
- **Patient as customer**—assuming quality care, patients rate "customer service" and "communication" as more important than even "bedside manner" when evaluating their health care experience.
- **Shopping for health care**—on average, consumers use three different websites during their health care research process and read 5.5 reviews before making a decision.[1]

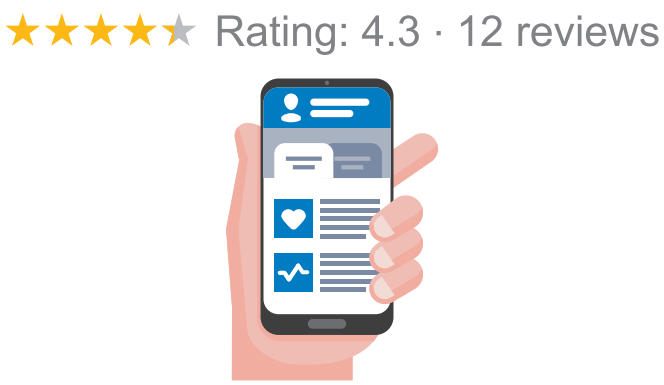
Today's health care consumers rely heavily on digital channels when selecting a provider. Some 51.1% of respondents across all demographics turn to the web when choosing a new primary care provider, as compared to 23.8% who first seek referrals from another health care provider, and only 4.4% who rely on their insurance provider or benefits manager.

The most important factor determining if a consumer chooses to make an appointment

with a doctor is ratings and reviews of the specialist or provider. Doctor referrals and facility ratings were second and third most important respectively.

To schedule that appointment? Among consumers surveyed, 63% prefer to make their appointment digitally, as compared to 37% by the more traditional phone call.

Gary Hamilton, CEO of InteliChart, a developer and provider of patient engagement solutions, notes that for years digital transformation has played a key role in helping industries such as finance, retail and hospitality boost customer engagement and consumer loyalty. As a direct result of the pandemic, health care is now keeping pace. Offering innovative digital health capabilities to improve patient engagement and streamline complex workflows can lead to higher quality, precision-oriented results, and in turn, positively affect patient loyalty.[2]



The most important factor determining if a consumer chooses to make an appointment with a doctor is ratings and reviews of the specialist or provider.

The ultimate goal of a patient-centered approach is to empower patients to become active participants in their care. This includes physicians and all medical staff developing good communication skills to address individual patient needs effectively. Digital tools such as patient portals and health care apps can and do play an increasingly important role in this process.

Hamilton adds that these tools also "give physicians a better opportunity for a targeted and accurate diagnosis while delivering options for care choice," allowing the use of virtual care, one-click scheduling, and easy online prescription fulfillment. A digital portal can be the physician's "front door to a quality health care experience, seamlessly integrated for the consumer's benefit. Current and prospective patients are likely to respond with appreciation—and ultimately loyalty—when health care providers adopt integrated digital platforms." [2]

With this increased reliance on websites and online reviews impacting provider selection, what if your practice's web presence does not adequately reflect your patient satisfaction levels? As digital consumerism in health care increases, it could result in patients rejecting good doctors even though they provide excellent care. Unfortunately, it only takes a few negative online reviews to hurt your practice's reputation.[3]

In a recent online post by the Forbes Agency Council, Ajay Prasad, CEO of GMR Web Team, a digital health care marketing agency, offered some suggestions to help physicians improve their practice's online reputation.

First, encourage your happy patients to leave reviews. In general, an unhappy patient is more active in expressing their dissatisfaction online, but happy clients don't always feel the need to express their satisfaction. Next, always respond to reviews, whether positive or negative. When you respond, you convey a positive message that the patient's experience matters to you and that you're willing to address all concerns.

Conduct patient satisfaction surveys post-appointment, and incorporate a rating system. This will enable you to measure experience levels and publicly share positive results. Use a digital patient engagement platform and incorporate telemedicine technology. Finally, train your team members for better patient service results, and display positive reviews on your practice's website.[3]

Be careful not to dismiss the importance of a positive digital presence if you believe your patient base is older and less inclined to do online research. The Press Ganey study found that all generations are increasingly more digital. In fact, the use of health care review, content and hospital websites has spiked among baby boomers since 2019—most notably, reliance on sites like Healthgrades and Vitals jumped 38%. For younger generations, the use of health care review sites is up 48.7%. Boomers are also more vocal online—57.1% have left a review for a provider or hospital vs. just 44.8% of millennials and Gen Z consumers.[1]

This recent research leaves no doubt that a health care provider's online reputation is of utmost importance, as well as engaging with your patients via the web. Maintaining that reputation will not only help prospective patients find and choose your practice in an increasingly digital marketplace, but can also improve patient care and build stronger relationships with your patients.

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Senate Gridlock Slows Progress Through Mid-March

The Missouri Legislature returned to session March 21 after the annual spring break. A flurry of activity is expected between now and the close of the session May 13.

The major feature of the session so far has been gridlock in the Senate. Seven senators calling themselves the "conservative caucus" have fought hard to split the Kansas City district currently held by U.S. Rep. Emanuel Cleaver, II, so Republicans could likely gain a 7-1 majority in Missouri's Congressional delegation, compared to the current 6-2 majority. The contentiousness has spilled into other issues, so only one piece of legislation—the state supplemental budget—has passed. A bipartisan group of senators led by Sen. Thompson Rehder (R-Scott City) held a press conference on March 9 criticizing the coalition for blocking legislation creating a sexual assault victims' bill of rights.

The information in this summary is drawn from legislative reports provided by the Missouri State Medical Association and the Missouri Foundation for Health, plus bill reports on the state House and Senate websites. This information is current as of March 19.

Supplemental Budget Passed: The only piece of legislation passed so far by both the House and Senate is the supplemental budget request. The primary element in the supplemental budget is funding for MO HealthNet (Medicaid) including the additional persons now covered by expansion.

Constitutional Amendment to Undo Medicaid Expansion: The full House approved and forwarded to the Senate HJR 117, which would send a constitutional amendment to voters attempting to undo the voter-approved Medicaid expansion. Provisions include giving the legislature the authority to determine specified appropriations for each Medicaid population, impose a work requirement for certain enrollees, and more.

Hospital Visitation Policies: The House approved HB 2116, which would require hospitals to allow a certain number of designated "essential support persons" to visit a patient in their care. MSMA notes several favorable amendments were made that would give an attending physician discretion over a patient's visitors and would protect typically restricted hospital areas from unauthorized visitors.

Medicaid Coverage for Postpartum Moms: A Senate committee approved SB 698, which would extend MO HealthNet coverage for new mothers from 60 days to 12 months. MSMA and other health advocates strongly support this bipartisan legislation, which is now before the full Senate.

Establishing Telemedicine Relationship: A measure to allow an online adaptive questionnaire to establish a physician-patient relationship (HB 2165) was approved by a House committee. This would continue a waiver put in place by the governor during the pandemic. MSMA opposes this legislation.

Needle Exchange Program: A Senate committee passed and forwarded to the full Senate SB 690, which would authorize safe needle exchange programs in Missouri. Though several of these programs already exist throughout the state, they currently operate in a legal grey area that risks running afoul of Missouri's drug paraphernalia law. MSMA supports this legislation.

Step Therapy: A Senate committee heard SB 959, which would allow patients to bypass step therapy protocols if a delay in treatment would be harmful to the patient, if a treatment is contraindicated for a patient, and more.

Rural Preceptors: House committee approval has been given to HB 2595, which would create a tax credit for physicians serving as preceptors for medical students in rural areas. The similar SB 801 has been heard in the Senate.

FOR MORE LEGISLATIVE UPDATE INFORMATION

- If you are an MSMA member, watch for their weekly *Legislative Report* and *5 Things MSMA Members Need to Know This Week* emails. If you're not an MSMA member, join now to receive these timely updates.
- Monitor the progress of bills at house.mo.gov or senate.mo.gov using the bill search feature.
- See the Missouri Foundation for Health's legislative updates and a tracking of health-related bills at https://mffh.org/our-focus/policy/legislative-updates

White Coat Day

SLMMS-member physicians were among the many making the rounds in the Missouri Capitol on March 1 during the Missouri State Medical Association's annual White Coat Day. Physicians and Alliance members visited the offices of their local legislators and observed the day's legislative proceedings. Pictured, attendees joined for the kickoff program that featured Sen. Jill Schupp from St. Louis, Sen. Bill White from Joplin and Rep. Jon Patterson, MD, from Independence. SLMMS members pictured in the front row (right center of photo) from left are George Hruza, MD, MBA; Edmond Cabbabe, MD; and Ravi Johar, MD. (Photo courtesy Missouri State Medical Association)

Judging Opportunity for Annual Science Fair

SLMMS will once again inspire future STEM leaders by sponsoring special scholarship awards for health and medicine projects submitted to the 2022 Academy of Science-St. Louis Science Fair. Due to COVID uncertainty, this again will be a transitional year with all projects submitted via the eFair option. This marks the third consecutive year the Academy of Science-St. Louis has conducted the fair 100% virtually.

Through a $1,000 grant from the St. Louis Society for Medical and Scientific Education, the Medical Society's charitable foundation, SLMMS will award five $200 scholarships plus certificates to the top health-related projects. The awards will be distributed to the winning students' Missouri MOST 529 educational accounts. According to the Academy of Science, the Science Fair encourages many students to open a 529 savings fund for the first time.

As a sponsor, SLMMS has been invited to provide judges to select our winning entries. Physician members as well as medical student members are welcome to participate.

Judging will take place electronically at designated times between April 22-27. The Academy will provide more details, including an eFair "how to" video, prior to the Fair. If you are interested in volunteering to judge, contact Dave Nowak in the SLMMS office at dnowak@slmms.org no later than Wednesday, April 20.

SLMMS is proud to continue our educational partnership with the Academy of Science-St. Louis Science Fair. While other organizations across the country were forced to cancel their events the past two years, St. Louis has been a national leader in continuing with an eFair option.

CDC Director Discusses COVID-19, Health Equity at WU

Centers for Disease Control and Prevention Director Rochelle Walensky, MD, MPH, discussed the pandemic response, health equity and the public health workforce during her March 3 question-and-answer session at Washington University School of Medicine. An infectious disease physician, Dr. Walensky obtained her undergraduate degree from Washington University in 1991.

She praised the nation's success with the COVID-19 vaccine. "It's extraordinary that we delivered 550 million vaccines in a year. Despite the hesitancy and divisiveness, there has been vaccine available to anyone who wanted one."

Another accomplishment of which she is proud is the CDC's modernization and speeding up of data collection and dissemination, including COVID-19 vaccine information in the *Weekly Morbidity and Mortality Report*. Earlier in the pandemic, the CDC was criticized for slowness in providing data.

The CDC has started a new center for forecasting and analytics that will be able to model coming events, she said. It will collaborate with academia and industry. "Our data sources will be key as we need to have a full line of sight of all the respiratory viruses that could lead to another pandemic," she commented.

"It's extraordinary that we delivered 550 million vaccines in a year. Despite the hesitancy and divisiveness, there has been vaccine available to anyone who wanted one."

Another issue she raised is managing public expectations, particularly public optimism when vaccines were first introduced. "The public heard that science is black and white. The truth is that science is gray. Science is not always immediate. … Sometimes you have to make decisions before you have that answer," she explained.

Improving health equity and reducing health disparities would reduce the severity of future pandemics, she said. "COVID-19 became a disease of the vulnerable. Those with less access to care and more comorbidities bore the higher burden of the disease."

In April 2021, the CDC declared racism a serious public health threat. Dr. Walensky continued: "We have spent a lot of time documenting the problem in health equity. I said, 'I don't want to document the problem anymore. I want to implement things that will fix the problem.'"

Dr. Rochelle Walensky at Washington University on March 3.

Dr. Walensky also discussed challenges to the public health workforce. "Before the pandemic, between H1N1, Ebola and Zika, the public health workforce lost between 60,000 and 80,000 jobs. During COVID, people have vacated the jobs," she said.

She cited a recent *MMWR* article reporting that about two-thirds of the public health workforce has a depressive or anxiety diagnosis, with about 10% having suicidal ideation.

She called for long-term, "longitudinal investment" in the public health workforce. "We also need to make sure this workforce feels valued and that it's a revered place," she added.

Medical schools and nursing schools have a role to play in ensuring the physician and nurse workforces—strained by the pandemic—are adequate to meet the need. "We need to make sure the next generation of trainees is as diverse as the populations they serve," she said.

Her message to the schools and aspiring health care workers: "This is our Super Bowl moment. We're all tired. This is what we were called to do and this is what we were trained for. Inspiring the next generation is so important."

Prior to joining the CDC, Dr. Walensky served as chief of the Division of Infectious Diseases at Massachusetts General Hospital from 2017-2020 and professor of medicine at Harvard Medical School from 2012-2020. She holds her medical degree from the Johns Hopkins University and her master's in public health from the Harvard School of Public Health. She is recognized for her work in HIV/AIDS.

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Narrowing the Racial Equity Gap in COVID-19

Outreach by health departments, health systems lays groundwork for continued efforts to advance health equity

By Jim Braibish, St. Louis Metropolitan Medicine

Early in the pandemic, African Americans in the St. Louis area were more than twice as likely to get sick with COVID-19 and die from it as their white counterparts. Today, the gap has narrowed considerably—thanks to the work of local health departments and health systems as they have conducted extensive outreach to minority and underserved communities.

As of March 2022, Blacks in St. Louis County have contracted COVID-19 at a rate of 21,058 per 100,000, compared to a rate of 14,585 for whites—meaning it is still 1.4 times more likely for Blacks in St. Louis County to get COVID-19 than whites. By contrast in May 2020, Blacks in St. Louis County were 3.5 times more likely to contract the disease.

The experience in St. Louis City is similar. Blacks in May 2020 were 2.4 times more likely to get sick with COVID-19, compared to 1.4 times more likely today. The disparity in death rates also has lessened similarly in both the city and county.

"We have made solid progress but we have a long way to go overall—and in particular with African American residents," said Faisal Khan, MBBS, MPH, acting director of the St. Louis County Department of Public Health. "We have to continue to work hard to earn and maintain trust. We know that it takes time to fight through decades if not centuries of racism and inequality, but we are staying in the fight."

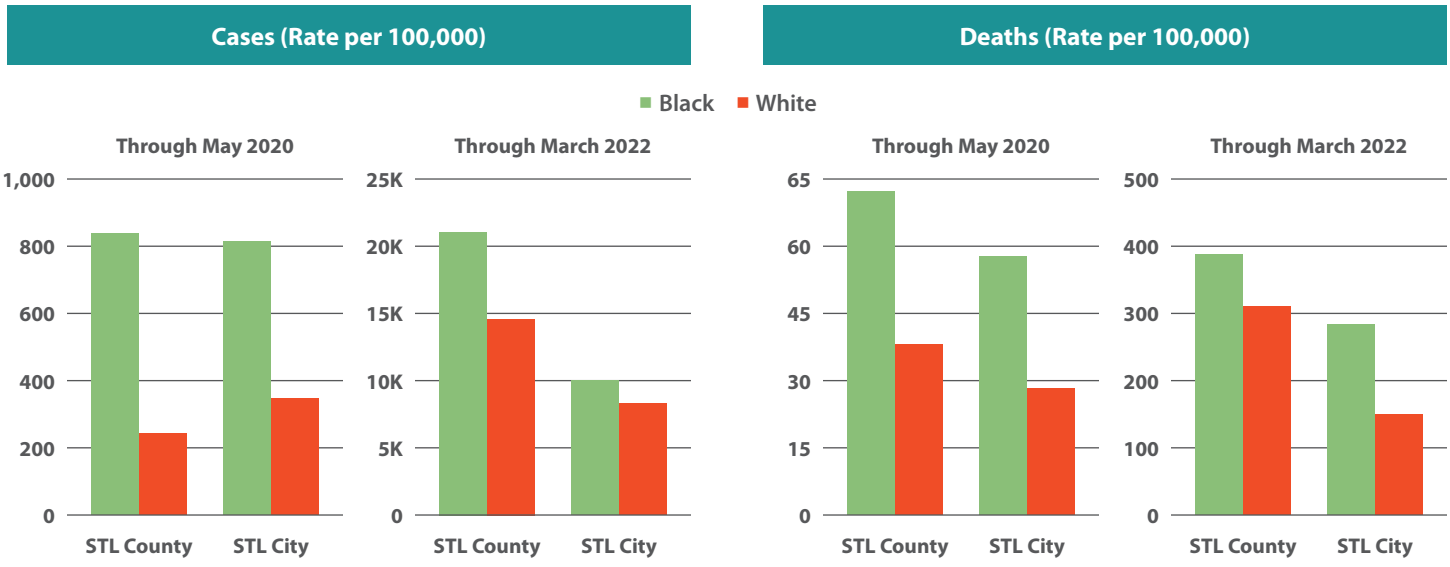
At the City of St. Louis Department of Health, those sentiments were echoed by Matifadza Hlatshwayo Davis, MD, MPH, department director: "There has been some progress made towards equity in health care services during the pandemic but there's still a lot of work to be done for the city, the region and the state. The disparities that have been highlighted by the pandemic didn't begin with the pandemic and it is unrealistic to expect they would end overnight."

Here are highlights of outreach efforts across the region.

St. Louis County Department of Public Health

DPH testing and vaccination outreach has primarily targeted north St. Louis County, particularly the area inside of Interstate 270 and north of Interstate 70. Six priority ZIP codes have been identified—63133, 63134, 63135, 63136, 63137 and 63138—encompassing such communities as Berkeley, Ferguson, Jennings, Riverview, Spanish Lake and Wellston.

INEQUITY: AFRICAN AMERICANS MORE LIKELY TO CONTRACT COVID-19



Data represent rates of total cases through the specified date. Data source: St. Louis City and County health departments.

Examples of St. Louis County Department of Public Health COVID-19 community vaccination events in 2021: (Left) A youth receives vaccine at the Rock Road Branch Library in St. Ann. (Center) DPH staff administer vaccine at a barber shop in North County. (Right) St. Louis County Executive Sam Page, MD, visits the registration table at a vaccination site in the Castle Point neighborhood. (Photos courtesy St. Louis County Department of Public Health)

Stakeholder groups. To earn trust and build relationships, the department set up a stakeholder group in North County made up of residents who provided valuable insights and assistance in reaching their communities. A second stakeholder group, made up of South County residents, sought to reach members of the Bosnian and Muslim communities with limited English proficiency.

Faith community, barber shop and beauty salon outreach. DPH partnered with churches, synagogues, mosques and temples across the county to arrange and support vaccination clinics in many neighborhoods. In addition, outreach teams visited more than 50 barber shops and beauty salons across North County to encourage vaccinations. They brought flyers, posters, masks and other materials for the businesses to share with their clients. Some of those small businesses ended up hosting vaccination clinics. In addition, DPH organized and hosted virtual town hall meetings that brought religious leaders and medical experts together to talk about the importance of vaccinations.

"Through these and other partnerships, DPH was able to administer more than 5,000 vaccine doses in 352 separate vaccination events as of the end of 2021, with more being conducted this year," said Christopher Ave, director of communications for the Department of Public Health. Overall, DPH estimates that 61% of county residents have received both vaccine doses (as of March 15).

Library partnership. The St. Louis County Library regularly hosted DPH vaccination clinics in four library branch locations in vulnerable communities. More than 3,000 additional vaccine doses have been administered at library branches.

Homebound vaccination program. DPH utilized partnerships with fire districts and emergency medical services to establish the first homebound vaccination program in the state. Through that initiative, more than 1,260 homebound residents and their caregivers were vaccinated. The DPH partnership with fire and EMS also filled in gaps in the state's program to vaccinate residents of long-term care facilities, resulting in nearly 700 more individuals getting vaccines. Fire and EMS partners also brought thousands of additional DPH vaccine doses out to neighborhoods throughout the year. And DPH partnered with the County Department of Human Services to vaccinate unhoused residents.

Multiple languages available. The county website promoting COVID-19 vaccination—ReviveSTL.com—can be displayed in nine languages besides English. Signage and forms are available in multiple languages including Spanish, Bosnian, Vietnamese, Arabic and others. The department has contracted to have interpreters available by telephone whenever needed.

Communications materials. To combat vaccine hesitancy and disinformation about the vaccines, DPH has produced dozens of videos, social media graphics, radio and television commercials, newspaper advertisements, billboards and other communications aimed at fighting myths with facts. The campaign included creation of the ReviveSTL.com website for residents to learn about and arrange for vaccinations as well as testing and other crucial services.

Ave said ReviveSTL.com attracted 185,000 unique visitors last year, and some 44,000 of them clicked through to make an appointment for a vaccination. "The campaign's digital advertising, which featured local faces and voices, was viewed 57 million times over the course of the year," he added.

continued

Equity Gap in COVID-19 … *continued from page 11*

Gift card incentive. Residents who began their vaccination process on or after Sept. 25, 2021, were eligible to receive $150 in grocery and gasoline gift cards after they had been fully vaccinated. DPH has distributed about 4,000 cards to more than 2,000 eligible residents since the beginning of the program—many of them in African-American communities.

Ave summarized: "All of our community outreach efforts will help us immensely moving forward. Because so much of our work focused on our most vulnerable residents, we will be able to leverage relationships and trust we established fighting COVID together as we intensify our efforts to combat other health problems such as sexually transmitted infections and opioid use."

City of St. Louis Department of Health

Neighborhood vaccination clinics. Following the Department of Health's series of mass vaccination clinics in the initial vaccine rollout stage, the department transitioned to neighborhood-based clinics held in conjunction with community partners. Trusted messengers in those neighborhoods assisted with identifying locations for the vaccination clinics and promoting the clinics. Ranging from churches to early childhood centers to community recreation centers, the dozens of sites hosting events have included the Urban League of Metropolitan St. Louis, Boys & Girls Club of Greater St. Louis, O'Fallon Park Rec Complex, Downtown St. Louis YMCA, Casa de Salud, St. Louis Housing Authority and others.

"Placing the COVID-19 clinics in neighborhoods is definitely a success story," said Harold Bailey, public information officer. "Doing this and working with trusted leaders in those neighborhoods removed some of the barriers individuals were facing and brought many residents to the clinics who probably would not have gotten vaccinated."

Homebound vaccinations. The Department of Health collaborated with the city Department of Human Services and the St. Louis Fire Department to deliver vaccinations to the homebound. DOH coordinated the project and secured vaccines and supplies. They were supported by volunteers from the Medical Reserve Corps and Community Organizations Active in Disasters who assisted with administering vaccinations.

Group and one-on-one educational sessions. The Department of Health provided upon request COVID-19 virtual and in-person COVID-19 education sessions to community groups and businesses. Information sessions also were provided during vaccination clinics across the community. Here, public health and medical officials participated in group and one-on-one question-and-answer sessions with residents.

"During these sessions, officials were available to dispel misinformation and answer questions from concerned residents. There were many occasions when individuals left the sessions at the clinics and went directly to the vaccination area and received a vaccination," Bailey described.

> "Placing the COVID-19 clinics in neighborhoods is definitely a success story."

City of St. Louis Department of Health COVID-19 community vaccination activities. (Left) Registration area for an outdoor vaccination event at O'Fallon Park. (Right) City Health Director Mati Hlatshwayo Davis, MD, MPH, right with a family at Vashon High School after the youths received their vaccines.
(Photos courtesy City of St. Louis Department of Health)

PPE distribution. Personal protective equipment including masks, hand sanitizer, COVID-19 care kits and other items were distributed to African Americans and other vulnerable communities, working in conjunction with elected officials and organizations such as PrepareSTL, Urban League, Cure Violence, Better Family Life and faith-based groups. A CDC Foundation grant obtained by the department's Clergy Advisory Board helped obtain some of the resources.

Communications materials. The Department of Health targeted COVID-19 messages in a variety of ways to African Americans and other vulnerable communities. The department has strategically placed radio and billboard ads, social media posts, door-to-door literature drops and used the local public access TV channel to distribute COVID-19 messages to African Americans and other vulnerable communities. Some of the radio ads that were recorded included messages from Jackie Joyner-Kersee, iHeart radio personality BJ the DJ, Ozzie Smith, Boys & Girls Club of Greater St. Louis leaders, Better Family Life leaders, and area African American religious leaders. Messages and vaccine materials were also translated to Spanish and Vietnamese.

Gift card incentive. A gift card incentive program targeting the entire community succeeded in attracting African Americans and other vulnerable communities to get vaccinated.

Medical homes. The Department of Health is working to ensure that individuals seeking vaccination have an opportunity to enroll in a permanent health care home through a federally qualified health center.

Bailey noted, "Our federally qualified health centers need to be prioritized as essential health care providers. For many of the region's wellness decisions, FQHCs aren't invited to the solutions table even though when it comes to the day-to-day health care services for many African Americans, they are shouldering the burden of the delivery of services."

BJC HealthCare

Vaccination events. BJC providers have targeted underserved areas with vaccination events at churches, businesses and larger community events.

"The sponsoring location has a champion, such as a pastor, who will go canvassing with us, spread the word through the community, and be visible at the event. Washington University School of Medicine is part of our planning and provides a physician presence to address clinical questions regarding hesitancy, the vaccine, other health conditions, etc.," said Karlos Bledsoe, director of strategy and operations for BJC community health improvement, a new section formed to advance health equity.

In addition, the St. Louis City and St. Louis County health departments attend the events to provide incentives and other health care information to help people get vaccinated and feel comfortable while doing so, he added.

"To overcome initial hesitancy, we leveraged research and community involvement. The suggestions from churches, businesses, schools, shelters, Washington University and the local health departments have increased the average vaccinations at each event from 24 to 58, more than doubling the vaccinations at each event," Bledsoe continued.

Children's Hospital mobile vaccinations. The Healthy Kids Express already has an established presence in underserved communities, where it has provided childhood vaccinations for years. Over 6,000 children have received COVID-19 vaccinations through Healthy Kids Express.

BJC "Show Me Hope" Behavioral Health Program. Door-to-door canvassing within a one-mile radius of a vaccination event was conducted by members of BJC's "Show Me Hope" COVID-19 disaster mental health team. They spoke with neighborhood residents and small business owners, encouraging them to attend the event and also providing information on disaster mental health and available mental health supports. "Show Me Hope" is funded by the federal government through the Missouri Department of Mental Health.

continued

BJC STRATEGIC PLAN TARGETS HEALTH INEQUITIES

BJC HealthCare has introduced a community health improvement strategic plan targeted at alleviating health inequities across the St. Louis region.

BJC will work with community partners in the City of St. Louis and north St. Louis County most impacted by inequities and will focus support around four areas significant to health and well-being: financial investment in the community, diabetes and healthy food access, infant and maternal health, and school health and wellness.

Leading the effort is Jason Purnell, PhD, MPH, who joined BJC in 2020 as vice president of community health improvement. Also an associate professor in the Brown School at Washington University, Dr. Purnell was the lead author of the 2014 landmark *For the Sake of All* report detailing health inequities in the region.

Community partnerships range from churches, businesses and community organizations. In line with the strategic plan, initial partnerships include work with two banks to increase lending in underserved areas, and joining with various food and nutrition organizations to address food insecurity and uncontrolled diabetes in north St. Louis.

Equity Gap in COVID-19 … *continued from page 13*

Home monitoring program. BJC and Washington University developed a home-based health monitoring program to follow COVID-19 patients. It offers both telephone and smartphone options to overcome the "digital divide" affecting underserved populations. To date, the program has monitored more than 22,000 COVID-19 patients. A research paper on the program was published in January in the *Journal of General Internal Medicine*; findings were that Black patients and those in underserved areas preferred daily phone calls to check on their conditions versus reporting them on a smartphone app.

"The home monitoring program allowed us to identify patients who really needed help right away," said Thomas Maddox, MD, professor of medicine and BJC vice president of digital products and innovation. "Without access to home monitoring, some of these patients may not have made it to the emergency room until they were a lot sicker, and more of them might have needed to be hospitalized."

Deployment of health care worker relief team. At the height of the omicron outbreak in January, a team of 44 health care professionals was assigned to assist staff at Christian Hospital in North County. The St. Louis Pandemic Task Force selected Christian to receive the assistance.

Moving forward, Bledsoe noted, "Beyond vaccines, we've built relationships and have commitments from community members, departments of health, and businesses to partner in delivering health care in these same communities. We're building the infrastructure to improve health care access and receptivity."

Mercy

Mercy's outreach efforts have been driven by data on its patient population showing a much higher incidence of COVID-19 cases and deaths among African Americans mirroring that of the general population, according to Danielle McPherson, DBA, Mercy system executive director for managed care contracting and operations. She also is the diversity officer for the Community Disparities Council, which is part of the system's Diversity, Equity and Inclusion Advisory Board.

"Through our work and the information shared through the St. Louis Metropolitan Pandemic Task Force, we found there was a large amount of vaccine hesitancy in the African American community, specifically driven by mistrust of the health care system," she said. "We took an approach that we need to educate and we need to vaccinate. We need to find ways the African American community will be able to begin to accept the safety and importance of vaccination."

"Representation matters. If you hear the information coming from people that look like you, the more likely you are to absorb the information."

In March 2021, just as widespread vaccine rollout was beginning, Mercy developed a video series featuring diverse physicians answering questions about vaccination from Mercy patients. The videos were made available on YouTube, LinkedIn, Facebook and Instagram. Live webinars also were held. An FAQ document was created for use by Mercy's community health workers.

Damian Findlay, DMD, MD, appears in a Mercy video targeting African Americans on the safety of COVID-19 vaccination. (screenshot of Mercy video)

One of the physicians featured in the videos is Damian Findlay, DMD, MD, who while an undergraduate at Tuskegee University met Tuskegee project survivors in his work as a research assistant. That gave him special credibility.

"Representation matters. If you hear the information coming from people that look like you, the more likely you are to absorb the information," McPherson said.

In delivering COVID vaccines, Mercy took its mobile unit to sites in North County and other areas. Various pop-up clinics were held.

McPherson's Community Disparities Council is an indication of Mercy's increased system-wide emphasis on health equity.

"We're infusing health equity into the core of our organization," she said. "It's being tied into our goals from leadership to individual departments. Health equity is being ingrained into the way that we're doing business."

Sound Health MSO Offers Practice Management Services

Sound Health Services, a private practice otolaryngology group, has formed Sound Health MSO, a management services organization (MSO) that provides a wide range of administrative services and management functions needed by physician practices to be successful in today's health care environment.

The practice said the MSO provides a viable alternative to private equity acquisition or hospital ownership for physicians committed to physician-owned private practice. The MSO offers multiple service and integration scenarios to address the needs and circumstances of different practices.

James Hartman, MD, otolaryngologist and president of Sound Health Services, noted, "Over the past few years, physicians have faced increasingly difficult challenges managing their practices. We now have a better way to utilize our expertise and resources in both practice management and practice integration to help physicians navigate the future and remain in private practice."

Save the Date

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Study: Vertical Integration Not Financially Beneficial for Physicians

Difference in compensation varies by specialty, market

By: Todd Zigrang, MBA, MHA, CVA, ASA, FACHE & Jessica Bailey-Wheaton, Esq.

A study released in the December 2021 issue of *Health Affairs* examined the correlation between hospital/health system ownership of physician practices and physician compensation. While a number of studies have analyzed the "rapidly growing trend" of vertical integration from the hospital/health system perspective, this is the first study to evaluate vertical integration from the physician practice perspective.[1]

The latest iteration in the push toward value-based reimbursement, which commenced in 2010 with the passage of the Patient Protection and Affordable Care Act, has driven the pursuit of closer relationships between hospitals and physicians through strategies such as vertical integration.

The researchers found that those physicians whose practices were acquired by a hospital or health system received slightly less compensation under hospital ownership, with some differences among specialties; further, hospital-owned physician practices were "associated with larger reductions in physician income in more competitive hospital markets and in nonprofit hospitals."[1] This article will discuss the study's findings and potential implications.

Vertical integration may be defined as "[t]he combination in one firm of two or more stages of production normally operated by separate firms."[2] Firms engage in vertical integration transactions in pursuit of certain benefits typically associated with this form of organization, including:

(1) The development of economies of scale,[3] i.e., the ability of large firms to produce large quantities of a good at a reduced cost per unit[4]

(2) The development of economies of scope,[5] i.e., the ability of large firms to produce a variety of goods more cheaply than producing those goods separately[4]

(3) Vertically integrated firms with centralized management structures can, if strategically constructed and implemented, create superior production efficiencies relative to more fragmented business structures and markets[3]

In the U.S. health care industry, vertical integration describes the "integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility or a physician group,"[6] which organizational model can provide additional benefits to health care delivery organizations, as well as, to the communities they serve.

The latest iteration in the push toward value-based reimbursement, which commenced in 2010 with the passage of the Patient Protection and Affordable Care Act, has driven the pursuit of closer relationships between hospitals and physicians through strategies such as vertical integration. In fact, from 2010 to 2018, hospital/health system ownership of physician practices increased 89.2%, from 24.1% of physician practices owned by a hospital/health system in 2010 to 45.6% by 2018. While research has found that hospitals profit from vertical integration (an approximately 19% increase in revenue), "little is known about the degree to which the income of physicians whose practices have been acquired has been affected."[1]

In analyzing physician compensation and physician practice ownership, the *Health Affairs* researchers examined data for 41,648 physicians (48.3% of whom were in independent practices and 51.7% of whom were in hospital-acquired practices), during the study period of 2014 through 2018. Physician compensation data was obtained from the Career Navigator Survey conducted by Doximity, "an online social network for physicians … that includes more than 70% of U.S. physicians." This data was then compared to information on practice ownership data during the period of 2010 to 2018 from the SK&A Office-Based Physicians Database administered by


Todd A. Zigrang


Jessica Bailey-Wheaton

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IQVIA, "a commercial database of health care providers, which provides a nearly complete sampling frame of U.S. office-based physicians," i.e., over 95% of office-based physicians.[1]

This compensation and ownership data was then matched up at the physician level and analyzed from a myriad of angles. First, the researchers examined the association between vertical integration and physician compensation among overarching physician specialty types—primary care, nonsurgical specialists, and surgical specialists. Second, the researchers analyzed whether this association varied by the tax status of the hospital—for-profit or nonprofit. Third, the association was examined by the competitiveness of the market in which the hospital operated (at the county level)—concentrated or competitive.[1]

The researchers noted that while physicians may not experience the same level of financial benefit from vertical integration as hospitals, there may be other, non-financial benefits associated with integration that were not captured by the study.

While physicians overall generally saw a small reduction in compensation of 0.8% post-integration (an absolute difference of -$2,987), the change in physician compensation post-integration varied depending on the specialty of the physician. Nonsurgical specialists experienced a *decrease* of approximately 2.4% (an absolute difference of -$9,652) post-integration, while primary care physicians saw an *increase* of approximately 1.2% (an absolute difference of $3,179) and surgical specialists saw an increase of 2.1%, in compensation (an absolute difference of $10,741), post-integration.[1]

The association between physician income and vertical integration also varied depending on the marketplace in which the hospital operated. Physician income did not significantly change post-integration in highly concentrated markets, but it did decrease approximately 2.2% in competitive (i.e., not highly concentrated) markets. Further, physicians acquired by a non-profit hospital saw a 1.9% reduction in their annual compensation; in contrast, physicians acquired by a for-profit hospital saw no statistically significant change in their income. The researchers theorized that the variances between these two attributes (competitive marketplace and tax status) may be due to "differential bargaining power between physicians and hospitals in less concentrated hospital markets and with for-profit hospitals.[1]"

The researchers noted that while physicians may not experience the same level of financial benefit from vertical integration as hospitals (or any financial benefit at all), there may be other, non-financial benefits associated with integration that were not captured by the study. For example, physicians may be willing to sacrifice some part of their income for a steady paycheck and consistent schedule; this "risk protection" may be more favorable than the variable income and scheduling that results from practice ownership.[1]

Additionally, physicians may appreciate hospitals taking on the administrative services (e.g., billing) and regulatory responsibilities (e.g., compliance), as well as interactions with insurance companies, that are required to operate a physician practice. As office-based physicians have experienced tightening reimbursement over the last few years, at the same time that they are being required to heavily invest in capital-intensive infrastructure such as health care information technology (e.g., electronic health records) that aggregates the requisite data and information required to report the metrics to the federal government (or commercial insurers), it is understandable that they may be willing to sacrifice some degree of autonomy and income for the relative stability of hospital ownership. In essence, physicians may prefer to make less money in return for being able to focus solely on treating patients.

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Real Estate: The Second-Highest Expense in Your Practice

Ideas to help you make the most of your next real estate transaction

By Sammy Pickett

When it comes to managing expenses in your practice, there are dozens of categories to evaluate: equipment, technology, loan costs and interest rates, sundries, marketing, and on and on they go.

Many practice owners are quick to shop out what they believe are the most obvious expenses, but few understand the impact of one of the largest expenses and how it can be dramatically reduced to increase profitability. The highest expense for most practices is payroll, followed by real estate. Real estate encompasses your monthly rent or mortgage payments, along with the property's operating expenses, maintenance fees, utilities, and janitorial costs.

If you consider these top two expenses, payroll and real estate, only one of them is really negotiable. With payroll, you can either pay people their value or they usually find another job that will. You may decide that you can cut staff, but if you need people, you need to pay them what they deserve or they will eventually leave.

Real estate, however, is 100% negotiable. You have the choice of leasing or owning, as well as being in an office building, retail center, a standalone building, or large medical complex with many other providers. You can choose the size of your space, the design, and the landlord you want to work with—or be your own landlord. And if you do own, you get to decide whether to buy an existing building, an office condo, or to develop your own building from the ground-up.

When negotiating the economic terms of a lease, you get to have a say in the length of lease, the desired concessions including build-out period, tenant improvement allowance, free rent, lease rates, annual rate increases and many other provisions.

Sammy Pickett

Sammy Pickett is the St. Louis agent for CARR, a leading national provider of commercial real estate services for health care tenants and buyers. CARR's team of experts assist with start-ups, lease renewals, expansions, relocations, additional offices, purchases, and practice transitions. Sammy can be reached at sammy.pickett@carr.us; the company website is www.carr.us.

With this many choices to evaluate, and understanding that each one affects the final economic outcome, why is it that so many practices fail to capitalize on their real estate opportunities? The short answer is that most practice owners and administrators simply don't have the knowledge and expertise in commercial real estate to understand how to make the most of these opportunities. They view real estate as a necessary evil instead of an incredible opportunity to improve profitability, reduce expenses and improve the quality of their patients' experience. When the correct approach is taken, you may actually look forward to it instead of dreading your real estate negotiation.

Real estate is 100% negotiable. You have the choice of leasing or owning, as well as being in an office building, retail center, a standalone building, or large medical complex with many other providers.

Let's take a look at three key ideas that will help you make the most of your next real estate transaction.

1. Timing

Every type of transaction has an ideal timeframe to start the process. When starting too early or too late, you communicate to the landlord or seller that you don't really know what you're doing. When that message is communicated, it hurts your ability to receive the best possible terms. For example, don't wait for your landlord to approach you on a lease renewal negotiation. Start by consulting with a professional so you can understand the ideal timeframe to start your transaction, come up with a specific game plan for what you want to achieve, and then you be the one to approach your landlord with renewal terms.

2. Representation

Landlords and sellers prey on unrepresented tenants who don't really know the market or what their options are. If the tenant was a Fortune 500 company, the landlord would approach them with a high level of respect, expecting that they either have a real estate broker hired to represent them or have a team of professionals internally that are well equipped to handle the transaction.

In contrast, when a landlord or seller starts speaking with a tenant who isn't represented, and whom they don't believe knows the market as well as they do, that tenant is not going to get the same level of respect through the process. This is because the landlord senses an opportunity to take advantage of a small tenant who is not an expert, doesn't have a full complement of real estate knowledge and skills, and who doesn't have adequate representation.

It is nearly impossible to emerge victorious from a negotiation without leverage and posture, which are created by having multiple options in the market.

When you understand that commissions are paid in commercial real estate just like they are in residential real estate—they are set aside in advance for two parties, not just one—then you understand there aren't any savings by not having a broker. And if there aren't any savings by not having a broker, then showing up without one only further detracts from your credibility.

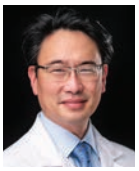
3. Leverage and Posture

It is nearly impossible to emerge victorious from a negotiation without leverage and posture, which are created by having multiple options in the market. If you limit yourself to one property, you are at the mercy of that owner. Since most landlords and sellers negotiate professionally, it is easy for them to know when you don't have other viable options.

Simply telling a landlord that you have a proposal from another landlord won't give you a strong enough posture. Most landlords look at unrepresented tenants and assume they do not know the market, do not understand all their options, and are not really serious about making the landlord compete for their business. Leverage and posture are created when you have the right timing, professional representation, an understanding of all your available options, and a detailed game plan of what you want to accomplish in order to capitalize on the market.

These three key ideas are the first of many factors that allow health care tenants and buyers to reduce their second highest expense which dramatically impacts profitability and cash flow.

PHYSICIAN NEWS


Dr. Albert H. Kim

Albert H. Kim, MD, PhD, a professor of neurological surgery at Washington University School of Medicine, has been named the inaugural William H. Danforth Washington University Physician Scholar. He is the first researcher named as part of the School of Medicine's new Physician-Scientist Investigators Initiative, which aims to recruit and retain elite physician-scientists whose work has already indelibly changed their fields. He also is a professor of genetics, of neurology and of developmental biology at the School of Medicine, and the inaugural director of the Brain Tumor Center at Siteman Cancer Center.


Dr. Ray Weick

Ray Weick, MD, has been named president of Mercy Clinic St. Louis and Mercy Clinic South. A family medicine physician with Mercy since 2004, Dr. Weick is the key liaison between Mercy Clinic physicians and advanced practice providers, key members of the Mercy network leadership team and boards of directors throughout the region.


Dr. Jason Newland


Dr. Cassandra M. Pruitt

The Department of Pediatrics at Washington University School of Medicine has named pediatricians **Jason Newland, MD**, and **Cassandra "Casey" M. Pruitt, MD**, to the newly created roles of vice chair of community health and strategic planning, and vice chair of outpatient health, respectively. The physicians treat patients at St. Louis Children's Hospital.

WELCOME NEW MEMBERS

Thank you for your investment in advocacy, education, networking and community service for medicine.

Sajid H. Ansari, MD
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Born 1970, MO Licensed 2002 ► **Active**
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Rohan Devanpalli-Ramaya, MD
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Born 1981, MO Licensed 2013 ► **Active**
Certified: Gastroenterology Nephrology

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MD, Sind Medical College, Pakistan, 1983
Born 1959, MO Licensed 2001 ► **Active**
Certified: Internal Medicine

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MD, Univ. of Illinois, 1984
Born 1958, MO Licensed 1993 ► **Active**
Certified: Internal Medicine

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MD, Yale University, 2010
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Born 1990, MO Licensed 2020 ► **Active**
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Born 1973, MO Licensed 2009 ► **Active**
Neurological Surgery

Nicolas S. Yozamp, MD
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MD, Washington Univ., 2015
Born 1989, MO Licensed 2021 ► **Active**
Certified: Internal Medicine

WELCOME STUDENT MEMBERS

Washington University School of Medicine

Lucas Cruz
Gino M. Dettorre

OBITUARY

Raymond W. Hellweg, MD

Raymond W. Hellweg, MD, a pediatrician, died March 18, 2022, at the age of 90.

Born in St. Louis, Dr. Hellweg earned both his undergraduate and medical degrees from Saint Louis University. He interned at St. John's Mercy Hospital, before completing his residency in pediatrics at Cardinal Glennon Children's Hospital. His medical studies were interrupted for two years while he completed military service as a captain in the U.S. Air Force at Richards-Gebaur Air Force Base in Kansas City. Dr. Hellweg was in private practice in pediatrics in north St. Louis County for over 36 years, and an active community volunteer in retirement. He was a past president of the St. Louis Pediatric Society. Dr. Hellweg joined the St. Louis Metropolitan Medical Society in 1962.

SLMMS extends its condolences to his wife Dorothy Hellweg; his children Joseph Hellweg, James Hellweg, and Julia Stolle; and his five grandchildren.

COVID-19 Survivors Face Increased Mental Health Risks

Data point to rise in anxiety, depression, substance use disorders, suicidal thoughts

A new study conducted by Washington University School of Medicine and the Veterans Affairs St. Louis Health Care System has found that people infected with COVID-19 were 60% more likely to suffer from mental health problems than those who were not infected. This in turn led to an increased use of prescription medication to treat such problems and increased risks of substance use disorders. The findings were published Feb. 16 in *The BMJ.*

Disorders arose within a year after recovery from the virus in people who had serious as well as mild infections. Examples identified included anxiety, depression and suicide ideation, as well as opioid use disorder, illicit drug and alcohol use disorders, and disturbances in sleep and cognition.

"We know from previous studies and personal experiences that the immense challenges of the past two years of the pandemic have had a profound effect on our collective mental health," said senior author Ziyad Al-Aly, MD, a clinical epidemiologist at Washington University. "To put this in perspective, COVID-19 infections likely have contributed to more than 14.8 million new cases of mental health disorders worldwide and 2.8 million in the U.S."

The researchers analyzed de-identified medical records in a database maintained by the U.S. Department of Veterans Affairs. They created a controlled dataset that included health information of 153,848 adults who had tested positive for COVID-19 sometime from March 1, 2020, through Jan. 15, 2021, and who had survived the first 30 days of the disease. Few people in the study were vaccinated prior to developing COVID-19, as vaccines were not yet widely available at the time of enrollment.

Statistical modeling was used to compare mental health outcomes in the COVID-19 dataset with two other groups of people not infected with the virus: a control group of more than 5.6 million patients who did not have COVID-19 during the same time frame; and a control group of more than 5.8 million people who were patients from March 2018 through January 2019, well before the pandemic began.

The majority of study participants were older white males. However, because of its large size, the study included more than 1.3 million females, more than 2.1 million Black participants, and large numbers of people of various ages.

Compared with those in the control groups without any infections, people who contracted COVID-19 were:

- 35% more likely to suffer from anxiety disorders
- Nearly 40% more likely to experience depression or stress-related disorders
- 41% more likely to have sleep disorders
- 80% more likely to experience neurocognitive decline

More worrisome, compared with people without COVID-19, those infected with the virus were 34% more likely to develop opioid use disorders and 20% more likely to develop nonopioid substance use disorders involving alcohol or illegal drugs. They were also 46% more likely to have suicidal thoughts.

Researchers also compared the COVID-19 patients with 72,207 flu patients, including 11,924 who were hospitalized, from October 2017 through February 2020. Again, the risk was significantly higher—27% and 45%—in those who had mild and serious COVID-19 infections, respectively.

"My hope is that this dispels the notion that COVID-19 is like the flu," Dr. Al-Aly said. "It's so much more serious."

Researchers compared people who were hospitalized for COVID-19 during the first 30 days of the infection to those hospitalized for any other cause. Mental health disorders were 86% more likely in people hospitalized for COVID-19.

988 TO BE NEW NATIONAL MENTAL HEALTH CRISIS LINE

A new three-digit crisis hotline number—988—will soon be available for persons in a mental health crisis. The number will go into effect July 16, 2022, in Missouri and across the nation. It will replace the National Suicide Prevention Lifeline and will connect hotline users with regional crisis call centers and crisis intervention teams. Missouri's proposed budget for FY 2023 sets aside $28.5 million to implement the program in the state.

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